Substance Abuse and Mental Health Services Administration
SAMHSA NEWS
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Workplace Substance Abuse Prevention and Managed Care

Contrary to the stereotype that most illicit substance users are unemployed, SAMHSA's 1999 National Household Survey on Drug Abuse showed that 60 percent of current illicit drug users age 18 or older are full-time workers. "What this means," says SAMHSA Deputy Administrator Joseph H. Autry III, M.D., "is that if we really want to address the use of illicit drugs, we have to address it in the workplace as well as in the community and in the home."

As part of the ongoing effort to eliminate drug use in the workplace, SAMHSA's Center for Substance Abuse Prevention (CSAP) launched a 3-year project in 1997 called the Workplace Managed Care (WMC) Substance Abuse and Early Prevention Initiative. The effort funds nine cooperative agreements to look at different workplace settings and interventions to develop effective approaches. (See *SAMHSA News* p. 14.)

The initiative is also propelled by another significant fact. "When you look at who are the largest purchasers of health care services related to substance abuse," says Dr. Autry, "you see that the workplace pays for about 50 percent of the treatment costs for substance abuse in this country."

As health care costs have continued to rise, this has prompted a widespread need for innovation, including increased use of managed care arrangements in service delivery and payment and a greater interest in prevention.

CSAP Program Manager of the WMC initiative, Deborah M. Galvin, Ph.D., explains, "A number of research findings supported the contention that prevention could potentially curb the costs of substance abuse treatment and related disease, and control workplace costs such as lowered productivity and increased absenteeism and litigation. The WMC program is designed to study the impact of a substance abuse prevention and early intervention program within a workplace

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Promising Practices for Children

SAMHSA's Center for Mental Health Services (CMHS) released three new volumes of promising practices to help families, communities, and caregivers build exemplary systems of care for children with serious emotional disturbances and their families.

The promising practices were developed by grantees funded by the CMHS Comprehensive Community Mental Health Services for Children and Their Families program. The program provides grants to states, communities, territories, and Indian tribes to improve and expand their system of care to meet the needs of children with serious emotional disturbances and their families. These grants enable communities to develop local systems of care highlighting service collaborations among mental health, child welfare, education, juvenile justice, and other appropriate services.

The new volumes, which are part of the *Systems of Care Promising Practices in Children's Mental Health* series, include the following:

- *Cultural Strengths and Challenges in Implementing a System of Care Model in American Indian Communities*, volume one, profiles five mental health projects for American Indian children. These projects integrate traditional American Indian helping and healing methods with the systems-of-care model. This volume was written by the National Indian Child Welfare Association.
- *Using Evaluation Data to Manage, Improve, Market, and Sustain Children's Services*, volume two, shares a wealth of ideas and experiences from these grant communities about using local data to help shape the delivery, management, and sustainability of community-based services for children and their families. This volume was written by the National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.
- *For the Long Haul: Maintaining Systems of Care Beyond the Federal Investment*, volume three, examines the fundamental strategies grantee communities should consider to maintain long-term financial stability with an emphasis on non-Federal funding sources. This volume was written by the Bazelon Center for Mental Health Law.

"Our evaluation shows children who have received services from this grant program have not only improved mental health but also improved school grades, improved living conditions, and reduced school absences and trouble with the law," said SAMHSA Administrator Nelba Chavez, Ph.D. (See *SAMHSA News* p. 3.) "Our job now is to put the information we have learned from our grantees into the hands of community-based caregivers and families around the country who care for the 3.5 to 4 million children living with serious emotional disturbances."

"This information will be highly useful to a wide variety of audiences—from direct service providers to policymakers to others who also are invested in the well-being of our Nation's children," said CMHS Director Bernard S. Arons, M.D. "We hope that this set of promising practices will continue to spur dramatic policy changes in the delivery of services to communities across the Nation and will further our efforts to create services in communities where they do not exist."

These three new volumes in the series supplement seven earlier volumes released in February 1999. The earlier volumes describe promising practices in training, service delivery, collaboration, school coordination, managed care, cultural competence, and roles for families in systems of care.

All 10 volumes are available free of charge from SAMHSA's National Mental Health Services Knowledge Exchange Network (KEN) at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-CMHS (2647) or (301) 443-9006 (TTY). Web access: Type **www.samhsa.gov**, click on SAMHSA's Clearinghouses, and then click on KEN.

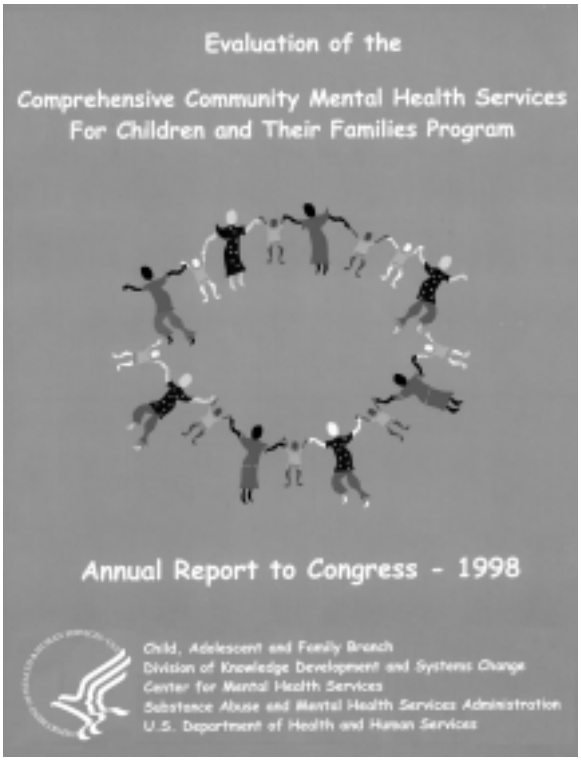
Systems of Care Help Youth With Serious Emotional Disturbances

A report published by SAMHSA's Center for Mental Health Services (CMHS) finds that a community-based, comprehensive "system of care" helps children and adolescents with serious emotional disturbances improve school performance and attendance, reduce contacts with the law, and lower levels of severe behavioral symptoms. According to an evaluation of the CMHS Comprehensive Community Mental Health Services for Children and Their Families program, children and their families, schools, and communities benefit when mental health services and other supports are integrated into a single service system to meet the diverse, highly individual, changing needs of children with serious emotional disturbances.

The *Report to Congress on the Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program, 1998*, also found high family satisfaction with the system-of-care approach. One year after their child entered the program, 75 percent of the nearly 725 surveyed families rated the quality of their child's mental health services as either "excellent" or "good." Similarly, 75 percent indicated they were asked for ideas and opinions concerning their child's treatment; 80 percent said that they "usually"or "always" had a choice in the range of services their child received.

The report focuses on the first 22 of the more than 60 sites supported by program since its inception.

"These findings demonstrate how communities can build on children's strengths and resilience by creating systems of mental health services and supports for children with serious mental health problems," said SAMHSA Administrator Nelba Chavez, Ph.D. "By working in partnership with families, and across health, education, child welfare, juvenile justice, and substance abuse programs, systems of care can make a critical difference in the lives of the Nation's 4.5 to 6.3 million children and adolescents with serious emotional disturbances."



Schools and mental health agencies made over two-fifths of the referrals into systems of care; social service, court, and correctional agencies added nearly another third of the referrals. Regardless of referring source, the benefits remain consistent. Children's academic achievement improved and impairment dropped, whether the children were among the most seriously impaired or the least impaired. The survey also reveals that continued contact with the justice system was 50 percent lower for program participants who had contact with the justice system before entering into the system of care.

The report also describes the characteristics of children and their families participating in the program, assesses improvements made by children who receive services continuously for at least 1 year, and evaluates how well program grantees set up and develop their systems of care.

CMHS Director Bernard S. Arons, M.D., observed, "Parents of children and adolescents with serious emotional disturbances have high-quality, community-based mental health service alternatives to distant residential or hospital programs. This Agency remains committed to ensuring that these children and adolescents and their families have the system of care that provides the tools and resources to foster growth, education, and resilience in the face of serious emotional disturbances."

For a copy of the report, contact SAMHSA's National Mental Health Services Knowledge Exchange Network (KEN) at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-CMHS (2647). Web access: Type **www.samhsa.gov**, click on SAMHSA's Clearinghouses, and then click on KEN.

Survey Shows Downward Trend Continuing for Youth Drug Use

Findings released this fall from SAMHSA's 1999 National Household Survey on Drug Abuse show that the decline in illicit drug use among young people age 12 to 17 that began in 1997 continued through 1999. Illicit drug use among the overall population 12 and older remained flat.

According to the trend data in the report, an estimated 9 percent of youth age 12 to 17 reported current illicit drug use in 1999, meaning they used an illicit drug at least once during the 30 days prior to the time of the survey interview. These data show a significant consistent downward trend over the last 3 years, from 11.4 percent in 1997 to 9.9 percent in 1998, and 9 percent in 1999.

The national trends in substance use presented in the 1999 report are based on data from a sample of 13,000 respondents using paper questionnaires similar to those used in prior years.

"We now have a consistent downward trend in drug use among teenagers that is very gratifying," said Health and Human Services Secretary Donna Shalala. "We must continue to build on our recent efforts to push the rate of drug use down and to address the real threat to our young people from tobacco and alcohol. Parents and teachers are our strongest allies in the battle to keep our young people free of drugs, alcohol, and tobacco."

Marijuana use for youth age 12 to 17 has also decreased since 1997 (9.4 percent in 1997, 8.3 percent in 1998, and 7 percent in 1999). Among youth age 12 to 17, the rate for cigarette use was 15.9 percent in 1999, not statistically different from 1998 (18.2 percent), but significantly lower than the rate in 1997 (19.9 percent).

The National Household Survey also showed that current use of cocaine, inhalants, hallucinogens, and heroin for individuals age 12 and older was stable, and use of smokeless tobacco decreased significantly from 3.1 percent in 1998 to 2.2 percent in 1999.

Among youth age 12 to 17, current use of cocaine, heroin, hallucinogens, and inhalants remained stable. The survey also showed there were no significant changes in the percentage of youths who perceive great risk in using marijuana once a month (30.8 percent in 1998 to 29 percent in 1999). Among youth age 12 to 17, perceived risk of cocaine use decreased significantly from 54.3 percent in 1998 to 49.8 percent in 1999.

Marijuana use for youth age 12 to 17 has decreased since 1997 . . .

National trends from the National Household Survey are generally consistent with results from other U.S. Department of Health and Human Services surveys. Both the Monitoring the Future Study and the Youth Risk Behavior Survey have shown a leveling or declining trend in illicit drug use, marijuana, and cigarette use among adolescents since 1997, after a period of significant increases in the early 1990s.

The rate of current alcohol use among youth age 12 to 17 and the general population has remained relatively flat for the past several years.

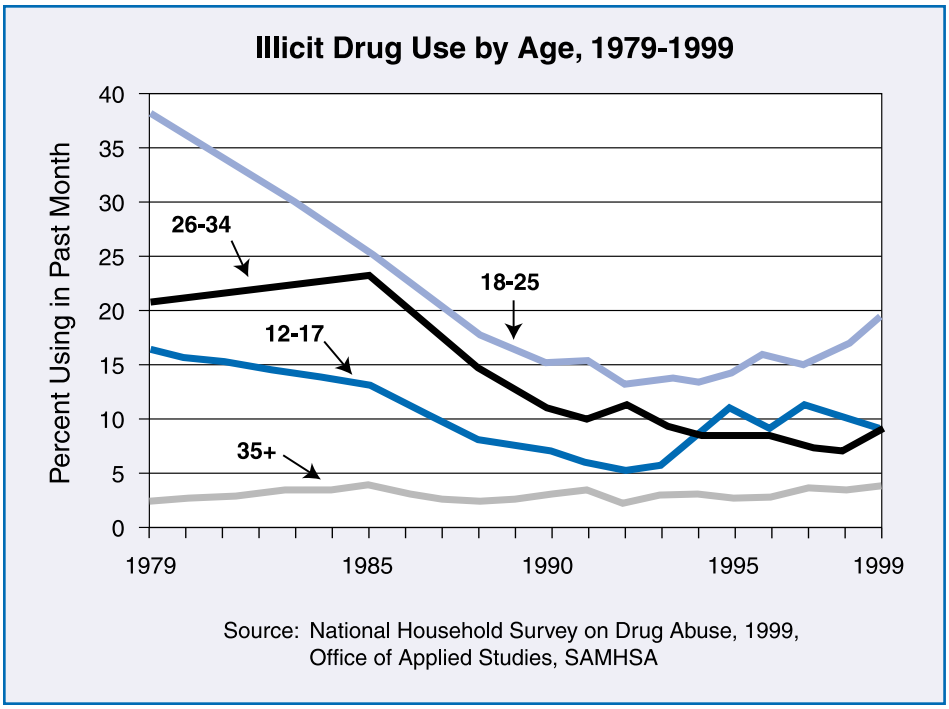
According to national trend data in 1999, 19 percent of youth age 12 to 17 reported that they drank at least once in the past month and 52 percent of Americans age 12 and older reported current alcohol use. In 1999, 7.8 percent of youth age 12 to 17 reported past month binge drinking and 3.6 percent reported past month heavy alcohol use.

Among adults age 18 to 25, the survey found increases in current illicit drug use. The rate increased between 1997 and 1999 (14.7 percent in 1997, 16.1 percent in 1998, and 18.8 percent in 1999). The rates for people age 26 to 34 and age 35 and older in 1999 have not changed significantly since 1994.

SAMHSA Administrator Nelba Chavez, Ph.D., said "Our efforts appear to be paying off in lower levels of drug use among teens, but we must do more to reduce illicit drug use among adults, particularly those age 18 to 25. The need for drug treatment is real and growing. People need to know that treatment can help people get off and stay off drugs."

The National Household Survey is based on a representative sample of the U.S. population age 12 and older, including persons living in households and in some group quarters such as dormitories and homeless shelters.

Over the years, SAMHSA has made improvements in the National Household Survey to provide better and more complete information on substance use. In 1999, a new, interactive, bilingual, computer-assisted questionnaire was introduced and a new sample design was used. The sample size was expanded almost fourfold to support the development of both national and state estimates of



Source: National Household Survey on Drug Abuse, 1999, Office of Applied Studies, SAMHSA

substance use. This new sample reflects information obtained from approximately 67,000 persons. Due to changes in the new methodology, national estimates from the expanded survey cannot be compared to data from prior surveys. The results from the expanded survey, however, will set a new baseline for future year-to-year comparisons.

For the first time ever, the survey provides state-by-state estimates of illicit drug, alcohol, and cigarette use by age group, as well as information about the brands of cigarettes that Americans smoke. This new, expanded data on demographic and geographic populations will be a valuable tool to help states and community-based organizations tailor their programs to their communities.

According to this new expanded survey, current drug use varies substantially among states, ranging from a low of 4.7 percent to a high of 10.7 percent for the overall population, and from 8 percent to 18.3 percent for youth age 12 to 17. Highlights from the expanded survey follow.

National Estimates

Illicit Drug Use

- An estimated 14.8 million Americans were current users of illicit drugs in 1999, meaning they used an illicit drug at least once during the 30 days prior to the interview. By comparison, the number of current illicit drug users was at its highest level in 1979 when the estimate was 25 million.
- Among youth age 12 to 17, 10.9 percent reported current use of illicit drugs in 1999. Marijuana is the major illicit drug used by this group. In 1999, 7.7 percent of youths were current users of marijuana.
- Among youth age 12 to 17, the percent using illicit drugs in the 30 days prior to interview was slightly higher for boys (11.3 percent) than for girls (10.5 percent). Although boys had a slightly higher rate of marijuana use than girls in this age group (8.4 percent vs. 7.1 percent), girls were somewhat more likely to use psychotherapeutics nonmedically than boys (3.2 percent vs. 2.6 percent).
- The rates of current illicit drug use for major racial/ethnic groups were 6.6 percent for whites, 6.8 percent for Hispanics, and 7.7 percent for blacks. The rate was highest among the American Indian/Alaska Native population (10.6 percent) and among persons reporting multiple race (11.2 percent). Asians had the lowest rate (3.2 percent).

Tobacco Use

- An estimated 66.8 million Americans reported current use of a tobacco product in 1999, a prevalence rate of 30.2 percent for the population age 12 and older. Of this total, 57 million people (25.8 percent) smoked cigarettes, 12.1 million (5.5 percent) smoked cigars, 7.6 million (3.4 percent) used smokeless tobacco, and 2.4 million (1.1 percent) smoked tobacco in pipes.
- Three brands account for most adolescent cigarette smoking. Of current smokers age 12 to 17, 54.5 percent reported Marlboro as their usual brand. Newport was reported by 21.6 percent of youth smokers, and Camel was reported by 9.8 percent. No other cigarette brand was reported by even 2 percent of youths.
- Race/ethnicity differences in usual cigarette brand used were evident among both adult and youth (age 12 to 17) smokers. Among adolescents, more than half of white (58.4 percent) and Hispanic (59.7 percent) smokers reported Marlboro as their usual brand. About three-quarters (73.9 percent) of African American adolescent smokers reported Newport as their usual brand.

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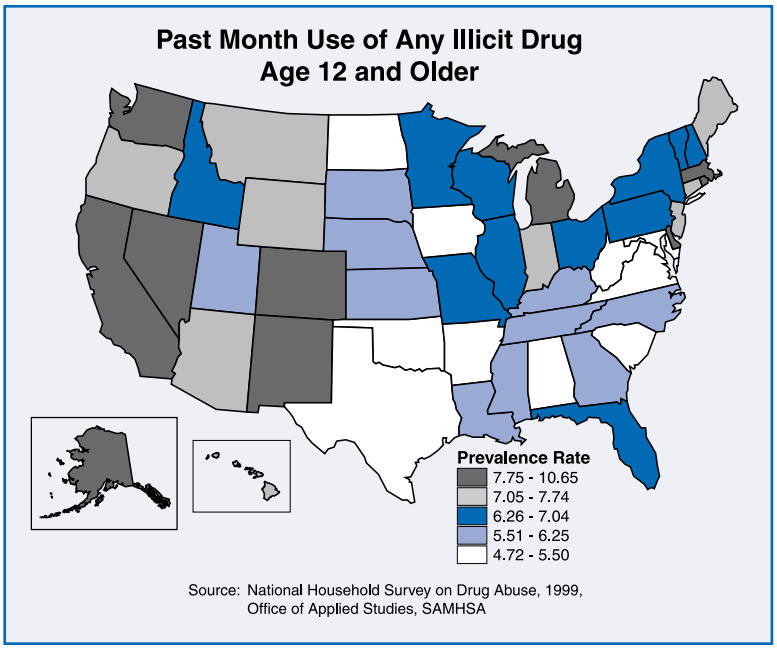

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Alcohol Use

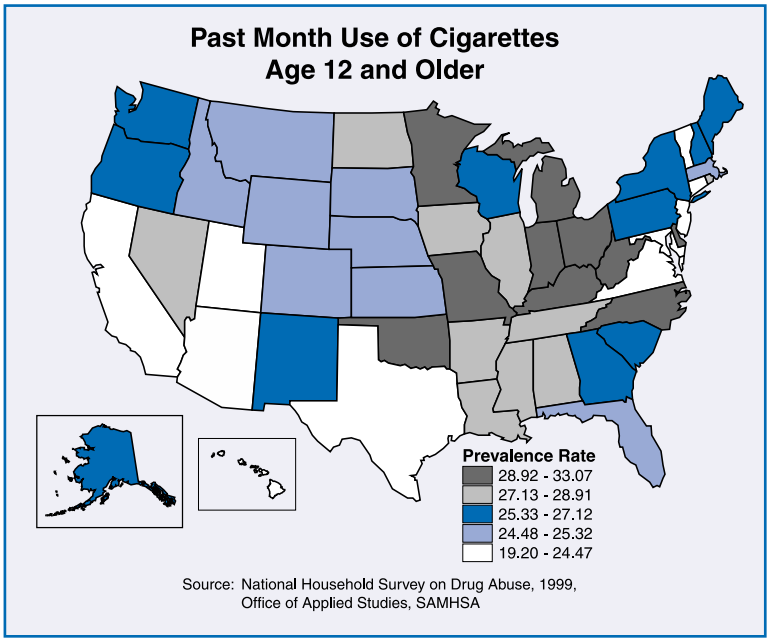
- In 1999, 105 million Americans age 12 and older reported current use of alcohol, meaning they used alcohol at least once during the 30 days prior to the interview. About 45 million of this group engaged in binge drinking, meaning they drank 5 or more drinks on one occasion during that 30-day period. Of these, 12.4 million were heavy drinkers, meaning they had 5 or more drinks on one occasion 5 or more days during the past 30 days.
- Although consumption of alcoholic beverages is illegal for those under age 21, 10.4 million current drinkers were age 12 to 20 in 1999. Of this group, 6.8 million engaged in binge drinking, including 2.1 million who would also be classified as heavy drinkers.

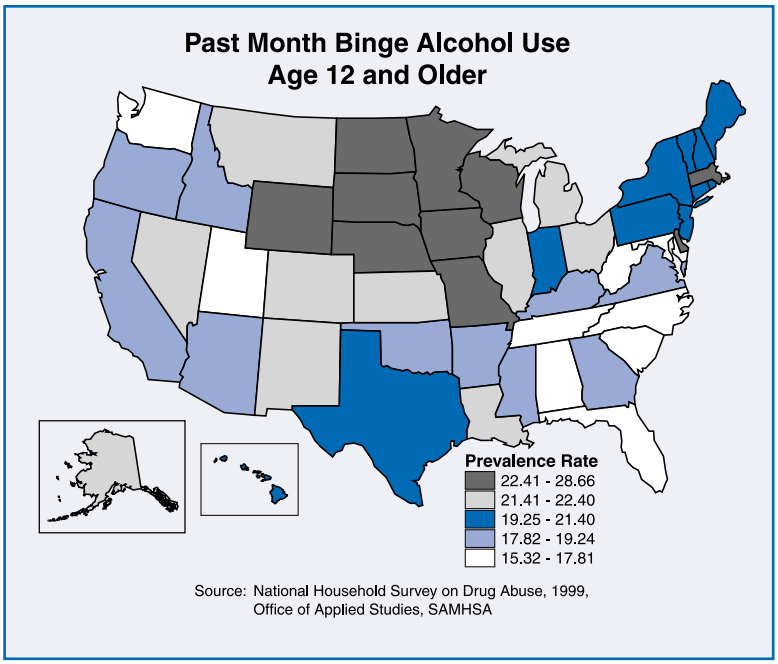
Trends in New Use of Substances (Incidence)

Trends in new use of substances are estimated using the data reported on age at first use from the computer-administered 1999 National Household Survey on Drug Abuse. Because information on when people first used a substance is collected on a retrospective basis, information on first-time use or incidence is always 1 year behind information on current use.

An estimated 2.3 million persons first used marijuana in 1998. This translates to about 6,400 new marijuana users per day. More than two-thirds of these new users were under age 18.

- There were an estimated 149,000 new heroin users in 1998, not statistically different from the 189,000 new users in 1997 or the 132,000 new users in 1996. Estimates of heroin incidence are subject to wide variability.
- A large proportion of the recent heroin initiates are young and are smoking, sniffing, or snorting heroin. Among the estimated 471,000 persons who used heroin for the first time during 1996 through 1998, a quarter (125,000) were under age 18, and another 47 percent (222,000) were age 18 to 25 at the time of first use. Only 37 percent reported having ever injected heroin by 1999. Most (89 percent) were living in metropolitan areas.
- An estimated 1.6 million Americans used prescription-type pain relievers nonmedically for the first time in 1998. This represents a significant increase since the 1980s, when there were generally fewer than 500,000 initiates per year. Among youth age 12 to 17, the incidence rate increased





from 6.3 per 1,000 potential new users in 1990 to 32.4 per 1,000 potential new users in 1998. For young adults age 18 to 25, there was also an increase in the rate of first use between 1990 and 1998 (from 7.7 to 20.3 per 1,000 potential new users).

- An estimated 1.6 million people began smoking cigarettes daily in 1998. About half of these new smokers were younger than age 18.
- An estimated 4.9 million people tried cigars for the first time in 1998, about 13,000 people per day. This represents a threefold increase in cigar initiation since 1991, when there were only 1.5 million new cigar smokers.

State-by-State Estimates

Estimates of substance use for all 50 states and the District of Columbia were developed using a small area estimation model that combines sample data from each state with a national regression model that includes local indicators related to substance use.

- Of the 10 states with the highest rates of current illicit drug use in the population age 12 and older, 6 were in the western region. Eight of the ten states with the lowest rates were in the southern region. However, within the regions, there was considerable variation. For example, Utah, a western state, had a relatively low past month prevalence rate of 6.2 percent. Delaware, a southern state, had one of the higher rates in the country (8.5 percent). Prevalence estimates ranged from a low of 4.7 percent (Virginia) to a high of 10.7 percent (Alaska).
- Six of the ten states that were in the highest ranking category for past month use of any illicit drug for persons age 12 and older were also in the highest group for youth age 12 to 17. The rate for youth was lowest for the state of Utah (8 percent). The highest estimate for youth was in Delaware (18.3 percent).
- The state with the highest rate of binge drinking for persons age 12 and older was North Dakota (28.7 percent). Most of the states with high rates were northern states. Seven out of the top ten states were in the Midwest. The state with the lowest rate of binge drinking was Maryland at 15.3 percent. Most of the states with the lowest rates of binge drinking were southern states.
- A number of the states that rank in the top 10 for past month cigarette use were not in the top 10 for illicit drug use or binge alcohol use. Those states include Kentucky, West Virginia, Ohio, Oklahoma, North Carolina, and Indiana.
- For cigarette use, five states ranked in the top 10 for both youth age 12 to 17 and for all people age 12 and older. These states were Kentucky, West Virginia, Minnesota, Delaware, and North Carolina.

SAMHSA's continuing efforts to reduce tobacco, alcohol, and illicit drug use in the United States include State Incentive Grants for Community-Based Action, already awarded in 20 states and the District of Columbia to support coordinated substance abuse prevention services. In addition, Regional Centers for the Application of Prevention Technology work to ensure consistent use of research-based prevention programs, practices, and policies. SAMHSA's new Targeted Capacity Expansion Grants also assist local governments and Indian tribal governments to address serious, emerging drug problems.

For a copy of the report, contact SAMHSA's National Clearinghouse on Alcohol and Drug Information (NCADI) at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Web access: Type **www.samhsa.gov.**

Cocaine Treatment Suggests Model for Methamphetamine

Imagine that you are addicted to a drug that gives you a burst of euphoric energy but also brings anxiety, insomnia, aggressive tendencies, cognitive impairment, and an increased risk of potentially fatal strokes and cardiac arrhythmias. The drug has actually changed your brain chemistry so that you are no longer capable of feeling pleasure without it. Every time you try to stop using it, you find yourself plunged into depression, fatigue, and confusion. The drug has also made you so paranoid that you no longer trust anyone who offers to help you.

That's what happens to people who become addicted to methamphetamine, a stimulant also known as "speed," "ice," or "crank."

Now, a new SAMHSA-funded study, part of the President's National Strategy for Combating Methamphetamine Abuse, is trying to find an effective way to treat methamphetamine abuse as use of the drug escalates. Launched by SAMHSA's Center for Substance Abuse Treatment (CSAT) in 1998, the Methamphetamine Treatment Project hopes to answer a key question: Will an effective treatment approach originally developed for cocaine users work for methamphetamine users as well?

Jointly coordinated by the University of California Los Angeles (UCLA) Drug Abuse Research Center and the Los Angeles-based Matrix Institute on Addictions, the 3-year project will determine the effectiveness of a comprehensive outpatient treatment protocol developed by the Matrix Institute. Seven substance abuse treatment programs around the country are now screening patients for methamphetamine use and randomly assigning those with problems to receive services based on either the Matrix model or the programs' own treatment as usual. A scientific advisory board composed of substance abuse experts helps with the study design and a community advisory board ensures that the project takes local people's needs and concerns into consideration.

"One of our goals here at CSAT is to take the results of research and try it in real-life settings to gain the information we need to begin working with communities to ensure the adoption of effective practices," says Jane Taylor, Ph.D., Director of CSAT's Division of Practice and Systems Development. "As methamphetamine makes its way across the United States, we are hopeful that soon we'll be able to say, 'Here's a treatment that's been found to be effective.' "

An Overlooked Crisis

Easily produced with everyday household products, methamphetamine use is moving east across the United States from the West and Southwest, with the midwestern states now seeing an influx of labs.

By now an estimated 9.4 million Americans, or more than 4.3 percent of the population, can say they have tried methamphetamine at some point in their lives, according to SAMHSA's 1999 National Household Survey on Drug Abuse. Data from other sources suggest a dramatic upswing in methamphetamine usage. According to SAMHSA's Treatment Episode Data Set, for instance, treatment admissions for methamphetamine and other stimulants more than doubled between 1993 and

Methamphetamine Treatment Project staff gathered at the Honolulu, HI, site include (top l. to r.): Alice Dickow, Honolulu site Principal Investigator; Norman Rodrigues, Honolulu site Researcher; (seated l. to r.): Cheryl Gallagher, CSAT Project Officer; and Patricia Marinelli Casey, Ph.D., Project Director.

1998, jumping from 2 to 5 percent of all treatment admissions during that period. In some areas, methamphetamine has now surpassed alcohol and cocaine as the number one problem among people seeking substance abuse treatment.

Although blue-collar or unemployed white men in their 20s and 30s are still the most typical users, methamphetamine use is now growing among women, Hispanics, Native Americans, young gay men and lesbians, and college students at dance parties. Methamphetamine's spread even affects those who have never used it. Children often test positive for use after being in rooms where the drug is manufactured. Laboratories sometimes catch on fire or explode. And the manufacturing process creates chemical residues that are environmentally hazardous.

Knowledge about how to treat methamphetamine abuse has not kept pace with the drug's growing popularity. Substance abuse treatment clinics have no established, proven method for treating methamphetamine addiction. And no medication exists yet to help ease users through the difficult withdrawal period.

"Part of the problem is the fact that methamphetamine epidemics have been limited to specific geographic areas," says Thomas Edwards, Jr., Chief of CSAT's Clinical Intervention and Organizational Models Branch. "The United States has experienced methamphetamine epidemics in the past, but the epidemics were either too brief or too localized to attract sustained national attention. Although currently the rate of methamphetamine abuse is higher in the western part of the country, use is spreading. More people are becoming aware of how dangerous the drug is, and the problem is receiving the national attention it deserves."

A Possible Solution?

"There has never before been a study of this magnitude of the treatment of methamphetamine users," says James M. Herrell, Ph.D., a Social Science Analyst in CSAT's Division of Practice and Systems Development. "We anticipate enrolling more than 1,000 people in the study using eight treatment approaches in seven cities." (See sidebar.)

According to Dr. Herrell, the project offers several approaches to knowledge development. At the very least, the project will collect extensive data about patients' current and past drug use, their treatment histories, their response to the various treatment techniques, and how factors such as gender, race, duration of drug use, and administration method affect that response.

"There is no single profile of a methamphetamine user," Dr. Herrell explains. "There are enormous differences from place to place." In Hawaii, for example, users almost always smoke the drug. In Montana, they typically inject it. In California, they use a variety of administration methods.

At the heart of the project is the Matrix model of outpatient treatment.

An unusually diverse study population will help clarify the impact such differences have on treatment. More than half of the study participants will be women, for instance. And the study includes the largest number of Asians and Pacific Islanders of any major clinical trial so far.

"By the end of the study, we'll have more information about who goes into methamphetamine treatment and how they respond to it than has ever been collected before," says Dr. Herrell. "We're also hopeful that one or more of the treatment approaches we're testing will prove to be particularly effective."

At the heart of the project is the so-called Matrix model of outpatient treatment. The Matrix Institute developed the original model in the early 1980s in response to an overwhelming demand for treatment for abuse of another stimulant—

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Project Sites

The Methamphetamine Treatment Project is using a complex multisite study design to test the effectiveness of various methods of treating methamphetamine use. In addition to a Coordinating Center jointly managed by the UCLA Drug Abuse Research Center and the Matrix Institute on Addictions, there are seven SAMHSA-funded sites:

- East Bay Community Recovery Project in Hayward, CA
- Family Recovery Center, EYE Counseling and Crisis Services in San Diego, CA
- Journey Recovery Chemical Dependency Treatment Program, South Central Montana Regional Mental Health Center in Billings, MT
- Matrix Center in Costa Mesa, CA
- New Leaf Treatment Center in Concord, CA
- San Mateo County Alcohol and Drug Services in collaboration with Pyramid Alternatives and Outpatient Drug and Alcohol Services for Asians in Belmont, CA
- Women's Addiction Treatment Center of Hawaii in Honolulu, HI.

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cocaine. With funding from the National Institute on Drug Abuse, the Matrix Institute developed a manual outlining its treatment protocol for cocaine users in the late 1980s. The Matrix Institute then adapted its model for use with methamphetamine users.

"Because methamphetamine users have more severe cognitive impairment, we have to go a little slower with the information we give them and do a lot of simplifying," says Richard A. Rawson, Ph.D., co-principal investigator of the Methamphetamine Treatment Project and the associate director of the Integrated Substance Abuse Programs at UCLA. M. Douglas Anglin, Ph.D., associate director of the Integrated Substance Abuse Programs at UCLA, is the principal investigator for the project.

In the absence of well-established treatment approaches, SAMHSA was drawn to the Matrix model for several reasons: The Institute had used the approach on several hundred methamphetamine users with apparent success. A manual clearly delineated the treatment protocols. And evaluations of the model over the past 15 years had already found encouraging results for both cocaine users and methamphetamine users. A 1994 study found relatively good results, with 40 percent of participants still abstaining from methamphetamine use after a year.

Now SAMHSA is testing the model's effectiveness in a large, multisite study. Key ingredients of the Methamphetamine Treatment Project's 16-week protocol include the following:

- Three 45-minute individual sessions focus on setting goals and monitoring the client's progress. Additional sessions are sometimes necessary if the treatment plan needs adjustment. By helping the client and therapist form a close relationship, these sessions become the "glue" that helps keep clients in the program.
- Early recovery groups teach clients in the first month of recovery how to reduce their cravings, schedule their time, stop using other substances, and find the community support services they need to recover successfully. The therapist who leads the session often invites clients succeeding in their recovery to serve as co-leaders and share their own experiences.
- Because clients typically find that stopping methamphetamine use is less difficult than remaining completely drug-free, ongoing relapse prevention groups are the most important part of the Matrix model. Each session begins with clients reporting on their progress. They then read a short educational piece on 1 of 32 topics and relate the information to their own experience. The session concludes with clients sharing their plans for constructive activities to prevent relapse.
- Family education sessions use audiovisual presentations, panels, and group discussions to teach families about the biological, behavioral, and social aspects of addiction. The Institute has found that getting families involved in treatment significantly improves clients' chances of staying in the program.
- Weekly 12-Step meetings optimally occur onsite among people the clients already know, including both clients in treatment and graduates of the program. In addition to providing support to participants, these onsite meetings also help orient them to meetings outside the program.
- Social support group meetings begin in the last month of treatment. These relatively unstructured meetings help clients establish new friends and find new activities unrelated to drug use.
- Relapse analysis occurs when a client relapses unexpectedly. This optional exercise helps both the client and therapist understand the factors that contributed to the relapse as a way of preventing it in the future.
- Regular urine tests reveal any undisclosed drug use. Positive results are used as the basis for discussion,

L to r: Carolyn Cudal, a participant at a CSAT-funded Methamphetamine Treatment Project site, the Women's Addiction Treatment Center of Hawaii (WATCH), discusses scheduling and planning with Matrix counselor Clay Wiggins.

Participants receiving the Matrix model of treatment services at the Women's Addiction Treatment Center of Hawaii (WATCH) find mutual support to be one of the most valuable parts of the program.

not recrimination. Some clients may also need breath tests to check for alcohol or marijuana use.

- A continuing care program provides additional information and support during the year following completion of the program.

A Closer Look

Using a common study design to facilitate comparisons, the Methamphetamine Treatment Project sites are trying to find out if the Matrix model can be successfully replicated and how it compares to the treatment the sites typically provided to methamphetamine users. The Women's Addiction Treatment Center (WATCH) site in Honolulu, HI, provides a view of one program up close.

"Because the methamphetamine problem started in the West, the Hawaii site has had a lot of experience," says Project Officer Cheryl J. Gallagher, M.A., a Public Health Advisor in CSAT's Clinical Intervention and Organizational Models Branch. "Out there, they've got families with three generations of methamphetamine users in one household—grandmother, mom, and the kids."

WATCH serves a clientele of primarily young, low-income women typically referred to the program by the legal or child protective services systems. Having a women-only site helps the women—most of whom have suffered domestic violence—feel safe and focused enough to explore the reasons behind their drug use, according to Alice J. Dickow, the principal investigator and director of WATCH.

Treating these women also poses special challenges, she says. The women typically use this drug to give them energy rather than a euphoric high and often don't see their daily use of small amounts as a problem. Also, an abundance of residential treatment in the state has made both users and the treatment community itself wary of outpatient treatment programs.

"There's such an emphasis on residential treatment here in Hawaii that getting our clients, family members, referral sources, and the treatment community to truly believe that outpatient treatment can be effective for methamphetamine users has been a challenge," says Ms. Dickow. She hopes the Methamphetamine Treatment Project will help change those attitudes.

In Hawaii, the project is comparing the Matrix model to a treatment-as-usual approach that focuses on relationship issues. Women in the treatment-as-usual group come together three times a week for 12 weeks. Healing and recovery classes that focus on domestic violence and relationships are key, says Ms. Dickow. Other activities range from "sobriety skills" to relapse prevention to art therapy sessions that allow women with limited literacy levels to express themselves.

Other women in the study follow the Matrix model with a few modifications to take into account regional differences. One standard exercise, for instance, introduces participants to the idea of scheduling as a way of helping them stay busy and avoid activities that might lead to relapses. "Here in Hawaii, time is a very different concept from the western notion of time," Ms. Dickow explains. "Instead of breaking time down into small chunks like a day-planner, we've tried to pick reference points that have some meaning for the women . . . like before and after meals."

Results from the Methamphetamine Treatment Project should be available in 2001. The *Journal of Psychoactive Drugs*, April-June, 2000, Volume 32, No. 2, has published a special issue devoted to CSAT's Methamphetamine Treatment Project. Additional information is also available through the project's Web site at **www.methamphetamine.org** or through SAMHSA's Web site at **www.samhsa.gov.**

—By Rebecca A. Clay

Marijuana Exceeds Heroin in 1999 Emergency Department Visits

Mentions of marijuana/hashish use for the first time exceeded mentions of heroin/morphine in drug-abuse-related visits to hospital emergency departments in 1999, according to SAMHSA's Drug Abuse Warning Network (DAWN) report issued in August. Drug-related emergency department visits among 12- to 17-year-olds decreased 11 percent, according to the same report.

The DAWN report also showed that drug-related emergency department visits remained relatively stable from 1998 to 1999, with an estimated 554,932 drug-related episodes in the United States and 1,015,206 drug mentions in these episodes.

The report, *Year-End 1999 Emergency Department Data from the Drug Abuse Warning Network*, provides estimates of the number of drug-abuse-related emergency department visits in the United States and 21 metropolitan areas.

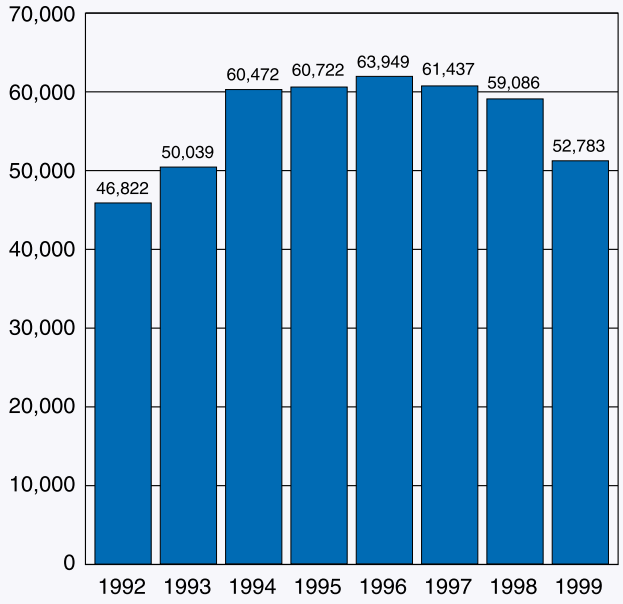
Analysis of the DAWN data showed that the four drugs mentioned most frequently in drug-related emergency department visits were statistically unchanged from 1998 to 1999, including alcohol in combination with another substance (196,277 mentions), cocaine (168,763), marijuana/hashish (87,150) and heroin/morphine (84,409).

The DAWN report focuses on comparisons between 1999 and the previous 2 years, as well as trends from 1990 to 1999 in substances most often mentioned during drug-related episodes.

Among the 1999 DAWN report findings:

- The total number of drug-related emergency department visits in 1999 continues a pattern of stability that began in 1994.
- Total drug-related episodes, from 1998 to 1999 were stable across gender, race/ethnicity, and most age groups.

Adolescent Drug-Related Visits To Emergency Rooms



Source: Drug Abuse Warning Network, 1999, Office of Applied Studies, SAMHSA

- The number of mentions of marijuana/hashish involving 18- to 25-year-olds increased 19 percent—from 22,907 in 1998 to 27,272 in 1999.
- Mentions of most prescription and over-the-counter drugs remained stable between 1998 and 1999.
- In drug-related emergency department visits, the most frequently cited motives for taking substances were dependence (37 percent) and suicide (32 percent).
- Overdose was the most frequently cited reason for drug-related emergency department visits (42 percent).

DAWN findings show significant variability between 1998 and 1999 among the 21 metropolitan areas in total drug-related emergency department visits. Three of these metropolitan areas had significant increases: Los Angeles posted a 21-percent increase, from 17,103 in 1998 to 20,678 in 1999; Denver registered an 18-percent rise, from 4,091 to 4,816; and Phoenix, a 17-percent increase—from 7,060 to 8,293.

Four metropolitan areas reported decreases in drug-related emergency department visits: New York had a 15-percent drop, from 36,142 down to 30,662; Boston's reported visits decreased 15 percent—from 13,657 to 11,669; New Orleans saw a 12-percent reduction—from 5,091 to 4,459; and Washington, DC, was down 11 percent—from 11,596 to 10,282.

For a copy of the report, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Web access: **www.DrugAbuseStatistics.samhsa.gov.**

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and managed care setting to discern the best practices and their costs."

Increasingly, Dr. Galvin says, services for substance abuse have integrated internal and external workplace components such as employee assistance programs, employee wellness programs, management, and health care organizations and providers.

"Many different strategies are out there, but we have had insufficient data to evaluate their impact," she says.

Now, the nine projects serve as catalysts in developing effective approaches, gathering data, informing the field, and influencing workplace and managed care policies.

Two Projects

The WMC initiative focuses on the innovative potential of integrating multiple components in the workplace to prevent substance abuse. A closer look at two of the nine projects provides examples of some of the approaches.

The Development Services Group (DSG) in partnership with Kaiser Permanente is examining a health maintenance organization model of service

delivery. At two Kaiser Permanente hospitals, DSG is comparing the impact on health care workers of traditional EAP services versus an enhanced employee assistance program.

Study participants are nonphysician employees and their families in Kaiser's San Francisco, CA, medical facility. They are being compared to a control group in another, nearby Kaiser facility.

DSG president and project director Alan Beckelman explains that the study "examines the effects of an innovative three-part substance abuse intervention consisting of parenting and teen workshops, a wellness program, and early screening and identification of alcohol and drug abuse."

DSG's early screening and identification component is particularly distinctive. Primary care providers conduct early screening and identification of alcohol and substance abuse using a new screening and referral system based on existing, empirically tested screening tools. The primary care provider asks a general question about substance use, and if the answer is affirmative, the patient is referred to a behavioral medicine specialist who administers a more thorough screening. Using a team approach, the physicians and behavioral medicine specialists screen, identify, and refer the employee to the appropriate service track.

DSG and Kaiser developed this two-tier process collaboratively with primary care providers and behavioral medicine specialists.

"This new screening tool has allowed us to overcome the objections of physicians who were concerned that if they found a

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substance abusing patient, there would be no way to refer that patient to treatment," says David Pating, M.D., with Kaiser's Chemical Dependency Recovery Program. "Now that the primary care provider and the behavioral medicine specialist are working together, referrals to appropriate interventions are occurring."

Project WISE (Workplace Initiative in Substance Education) conducted by the Behavioral Health Research Center of the Southwest (BHRCS) at Lovelace Health Systems is another WMC project. Lovelace provides health care to about 10 percent of the population of New Mexico (approximately 158,000 people) and employs about 3,300 people, 70 percent of whom use the Lovelace health plan.

BHRCS director Sandra Lapham, M.D., M.P.H., worked with the employee wellness program and employee assistance program coordinators to develop Project WISE to enhance the substance abuse prevention program at the Lovelace hospital center. Employees at the system's satellite primary care clinics, multispecialty care clinics, and administrative offices did not receive enhanced services. They served as the comparison group.

Project WISE focuses on preventing and decreasing risky drinking.

"Alcohol abuse is a serious problem in New Mexico," says Dr. Lapham. "The state ranks second nationally per capita in alcohol-related traffic fatalities. Also, we didn't think that people would answer questions truthfully about illegal drug use in a health-risk appraisal connected with their workplace. By identifying high-risk alcohol users, we would reach many drug users, too."

The enhanced program incorporates questions about alcohol use into an existing

Nine Workplace Managed Care Projects

In making the WorkPlace Managed Care (WMC) grants, CSAP called for partnerships between managed care providers and employers to enhance existing programs and assess their impact. According to baseline data, the nine grantees cover approximately 25 work sites nationwide and provide interventions to more than 52,600 employees. They range from close collaborations to loosely knit partnerships among health care provider organizations, human resource departments, employee assistance programs, employee wellness programs, security programs, and other entities.

The organizations funded through the CSAP program and the main thrust of their work are as follows:

- **Behavioral Health Research Center of the Southwest**, in cooperation with Lovelace Health Systems, is evaluating the effectiveness of the health care organization's employee assistance, drug testing, and employee wellness programs.
- **Development Services Group, Inc.** (DSG), in partnership with Kaiser Permanente, is examining the effects of an innovative three-part intervention that includes parenting and teen workshops, a wellness program, and early screening and identification of alcohol and substance abuse by primary care providers.
- **Greater Detroit Area Health Council,** in partnership with the University of Michigan and M-CARE, is determining the effectiveness of its DrinkWise program, an alcohol management program that helps individuals reduce or quit alcohol consumption before it becomes problematic.
- **ISA Associates**, in partnership with the Integon Corporation and PARTNERS National Health Plan of North Carolina, is studying the impact of group sessions and other educational interventions on self-reported health behaviors and medical claims information.
- **Pacific Institute for Research and Evaluation** (PIRE), in partnership with PeerCare and a major transportation company, is evaluating the company's peer-to-peer substance abuse prevention/early intervention program.
- **Stanford University** and its WMC CopingMatters Program are assessing the effectiveness of their interactive Web site with employees of a Silicon Valley high-tech corporation.
- **University of Virginia**, in cooperation with QualChoice and the Institute for Quality Health program, is examining the impact of service enhancements on the identification of problems, use of health services, workplace performance, manager/employee satisfaction, and medical utilization.
- **The Walsh Group,** in cooperation with a major technology manufacturing corporation, is evaluating the impact of drug testing and workplace education programs on the company's managed care costs.
- **Weyerhaeuser Forest Products Company,** in partnership with the University of Washington, is reviewing a peer helper network within a managed and nonmanaged care model to test the effects on substance and alcohol abuse.

health risk appraisal. Following the appraisal, employees receive personalized feedback including, as appropriate, the offer of one-on-one counseling or targeted booklets, videos, or other materials.

Project WISE also raises general awareness with inserts in staff newsletters, participation in health fairs, and videos. The employee assistance program coordinator trains supervisors to recognize signs of possible drug or alcohol abuse in employees.

Health Educator Karen A. Kranich conducted substance abuse prevention programs in the past, but this was her first involvement in a program as extensive as Project WISE. "I come from a holistic background and have always seen well-being as more than nutrition and exercise, so I found this extremely useful," she says.

"What helped our program," she adds, "was to wrap information about substance abuse in the blanket of a broader health context. We can tell employees that we are looking at their overall health, which includes blood pressure, cholesterol, and many other things, including substance abuse prevention. It's not 'call this number to get information about substance abuse.' "

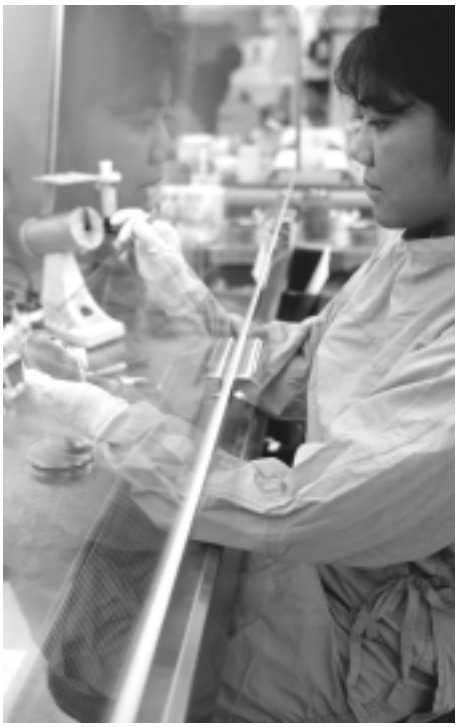
Preliminary Findings

Dr. Galvin says that the initiative is currently putting together data from many sources. "These data have never been mixed before," she says. "We're looking at health care, human resources, and demographic data." Each organization will complete its own study in the next few months and a cross-site evaluation team will see if any findings from the nine projects can be generalized.

Early results of the WMC initiative suggest the following:

- Addition of substance abuse prevention materials to existing workplace health promotion programs can contribute to improved attitudes and behavior regarding substance abuse without decreasing employee receptivity to the other program offerings.
- Stress management programs may achieve improvements in substance abuse attitudes and behaviors even without explicit substance abuse education materials.
- Workers who participated in health promotion/substance abuse prevention interventions were more likely to access health care for alcohol, drug, and related mental health problems.

Lovelace Health Systems health educator Karen Kranich helped introduce many of the elements of Project WISE to Lovelace staff.



Dr. Galvin says that a knowledge exchange workshop will be held in the early summer of 2001 to share findings with human resource departments, managed care organizations, insurance programs, and others involved with WMC.

In the meantime, the May 2000 issue of the *Journal of Behavioral Health Services & Research* contains a special section of five detailed articles on the Workplace Managed Care Substance Abuse Early Prevention Initiative. Information about the initiative, including interview guidelines and other tools, descriptions of the study sites, journal articles, and other materials can be accessed by visiting the following SAMHSA Web site: **wmcare.samhsa.gov.**

States Expand Managed Behavioral Health Care Initiatives

The number of state governments with managed health care programs for treatment of mental and addictive disorders has tripled in 3 years, from 14 in 1996 to 42 in 1999, according to the latest analysis of SAMHSA's Managed Care Tracking System.

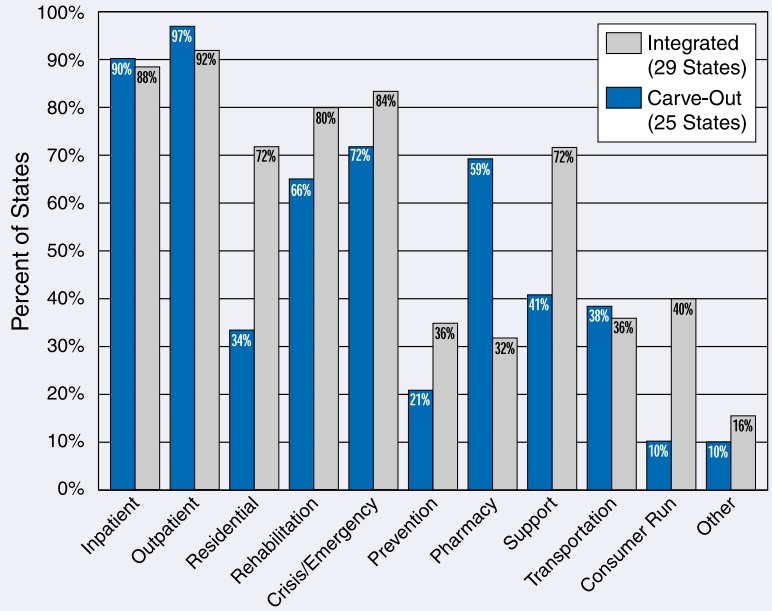
Developed by SAMHSA's Office of Managed Care, this annual report–*State Profiles, 1999, On Public Sector Managed Behavioral Health Care*–shows that states increasingly use managed care to meet their needs for treatment of mental and addictive disorders (often called "behavioral health care"). The report cites Medicaid as the largest source of funding for these public (government agency) behavioral health care programs.

SAMHSA Associate Administrator for Managed Care Eric Goplerud, Ph.D., said, "As SAMHSA and the states seek to encourage more alternatives to institutional care, this snapshot of all public managed behavioral health care programs indicates that programs operating on their own and separate from managed physical health care are more likely to provide support services of rehabilitation and consumer-run services."

Among the report's major findings:

- There is wide diversity in the types of organization, financing, and structure among the states' managed behavioral health care programs. Some cover multiple populations or areas, and some are limited to certain populations or to one county or region. Also, some are risk-based, whereas others remain fee-for-service through administrative service-only contracts.

Behavioral Health Services in Public Managed Behavioral Health Care Programs, Integrated Versus Carve-Out Models, Medicaid and Non-Medicaid, 1999



Mental Health Services (Mental Health Only and Combined Mental Health/Substance Abuse Programs)

Source: SAMHSA Managed Care Tracking System, 2000.

- While Medicaid agencies most often serve as the primary purchaser for managed behavioral health care programs, state mental health and substance abuse authorities work in collaboration with Medicaid agencies, particularly for "carve-out" (stand-alone) mental health and substance abuse treatment programs.
- Carve-outs—those managed behavioral health care programs separate from managed physical health care programs—are more likely to provide such community-based services as residential, rehabilitation, support, and consumer-run services. Integrated managed health care programs—those covering both behavioral and physical health care—are more likely to provide pharmacy services.

The SAMHSA report examines how state mental health and substance abuse managed care programs are organized, administered, financed, and delivered. States are evenly split between integrated programs and carve-out programs . The SAMHSA report identifies many important differences in these programs.

The data analysis scrutinizes all public behavioral health care programs in a national summary of findings, state-specific information, and program descriptions. The tracking project will publish a supplement updating the profiles later in 2000.

For a copy of the state profile report, contact SAMHSA's National Clearinghouse on Alcohol and Drug Information (NCADI) at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Web access: Type **www.samhsa.gov**, click on SAMHSA's Clearinghouses, and then click on NCADI.

Recovery Month Observed

Substance abuse treatment providers and people in recovery from alcohol and drug abuse joined with elected officials, policymakers, education leaders, judges, health providers, the faith community, and many other sectors to celebrate the 11th observance of National Alcohol and Drug Addiction Recovery Month in September. The 2000 Recovery Month theme, "Recovering Our Future: One Youth at a Time," served as a catalyst to generate local activities highlighting the need to support and expand substance abuse treatment programs for youth.

The annual observance of Recovery Month, coordinated by SAMHSA's Center for Substance Abuse Treatment (CSAT), promotes the societal benefits of substance abuse treatment, lauds the contributions of treatment providers, and promotes the message that recovery from substance abuse in all its forms is possible.

"Children should not be punished for their addiction," said SAMHSA Administrator Nelba Chavez, Ph.D. "An addiction is not a crime. An addiction is a disease that needs to be treated like any other."

The launch coincided with the release of a SAMHSA report, *The Treatment Episode Data Set (TEDS), 1993-1998*. The report revealed that adolescent (age 12 to 17) treatment admissions for marijuana use increased by 155 percent (30,832 to 78,523) from 1993 to 1998, with 49 percent of all those admitted for marijuana treatment under age 20. The number of adolescent admissions for treatment of dependence on any drug increased 45 percent (95,378 to 138,038) from 1993 to 1998. The TEDS report provides information on the demographic and substance abuse characteristics of the more than 1.5 million admissions to treatment facilities that receive state alcohol and drug agency funds. (See *SAMHSA News*, p. 18.)

Major improvements in treatment for adolescent marijuana use were also announced at the launch. The CSAT-sponsored Cannabis Youth Treatment Multisite Study: Preliminary Findings outlines five effective models used to treat adolescents depending on the severity of the marijuana abuse. Using these five marijuana treatment models, the percent reporting no past month abuse or dependence symptoms increased from 19 percent to 61 percent. The five treatment models in the study were able to reduce days of use of marijuana by 36 percent and reduced, overall, the number of adolescents with past month substance-related problems by 61 percent.

CSAT Director H. Westley Clark, M.D., J.D., M.P.H., observed that, "This is the largest experiment ever conducted on outpatient adolescent treatment and involves a collaboration that bridges the gap between research and practice. We are producing manuals of each of the five treatment protocols so that these exemplary treatments can be replicated at treatment facilities nationwide."

Recovery Month activities included: Community Forums throughout September in 16 cities; youth-targeted radio public service announcements; "Run for Recovery," a greater metropolitan Washington, DC, 5K Run/Walk; a

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teleconference; and Web-based activities. More than 50 national, regional, and local organizations and coalitions partnered with CSAT on Recovery Month to coordinate this year's activities. Federal partners included the Drug Enforcement Administration, the Department of Justice's Office of Juvenile Justice and Delinquency Prevention, National Institute on Alcohol Abuse and Alcoholism, National Institute on Drug Abuse, Office of National Drug Control Policy, the Department of Defense, and the Department of Labor.

"If children reach adulthood without using illegal drugs, alcohol, or tobacco, they are unlikely to develop a chemical-dependency problem later in life," said Barry R. McCaffrey, Director of the White House Office of National Drug Control Policy. "Drug dependence is a chronic, relapsing disorder that exacts an enormous cost on individuals, families, businesses, communities, and nations. Treatment can help people end dependence on addictive drugs. Treatment programs also reduce the consequences of addiction on the rest of society. Providing treatment for America's chronic drug users is both compassionate public policy and a sound investment," he added.

For a Recovery Month kit containing targeted and media outreach materials, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at 1 (800) 729-6686 (English and Spanish). Web access: Type **www.samhsa.gov**, click on SAMHSA's Clearinghouses, click on NCADI, and then click on CSAT Program Resources. The kit also contains valuable statistics and resource materials as well as contact information for the organizations and coalition partners that supported and helped organize the observance.

Data Show Increase in Marijuana Treatment Admissions for Youth

SAMHSA released a report this fall, the *Treatment Episode Data Set (TEDS): 1993-1998*, revealing that adolescent (age 12 to 17) treatment admissions for marijuana increased by 155 percent (30,832 to 78,523) from 1993 to 1998, with 49 percent of all those admitted for marijuana treatment falling below age 20. The number of adolescent admissions for treatment of dependence on any drug increased 45 percent (95,378 to 138,038) from 1993 to 1998.

The TEDS report provides information on the demographic and substance abuse characteristics of the more than 1.5 million admissions, primarily to treatment facilities that receive state alcohol and drug agency funds. The data are submitted to states by SAMHSA's Office of Applied Studies by state substance abuse agencies.

"The dramatic increase in adolescent admissions for treatment of marijuana use shows that marijuana is a dangerous and addictive drug," said SAMHSA Administrator Nelba Chavez, Ph.D. "Fortunately, as we saw an increase in adolescent marijuana use early in the 1990s, we had the foresight to begin developing appropriate and effective treatment models for marijuana dependence," she added, referring to the Cannabis Youth Treatment Multisite Study sponsored by SAMHSA's Center for Substance Abuse Treatment.

Other principal findings from analysis of TEDS revealed:

- Adolescent admissions for marijuana abuse grew from 32 percent of adolescent admissions in 1993 to 57 percent in 1998, and accounted for most of the increase in adolescent admissions.
- Adolescent admissions for alcohol abuse dropped from 49 percent of adolescent admissions in 1993 to 25 percent in 1998.
- Nineteen percent of those admitted to treatment for methamphetamine/amphetamine use had used the drug by age 14, and more than half (53 percent) by age 18.
- Alcohol accounted for almost half, or 47 percent, of all 1.6 million treatment admissions (age 12 and older) in 1998, with 42 percent of those admissions involving both alcohol and drugs.

Adolescents

TEDS data on adolescents also showed that of the admissions for youth age 15 to 17, 58 percent were admitted for primary marijuana use. An additional 26 percent were admitted for primary alcohol abuse—either alcohol only or alcohol with a secondary drug.

Half (50 percent) of adolescent admissions for marijuana were referred through the criminal justice system. More than half (55 percent) of adolescent admissions for alcohol only were referred through the criminal justice system.

Seventy percent of adolescent (age 12 to 17) admissions were male. This proportion was heavily influenced by marijuana admissions where 76 percent were male.

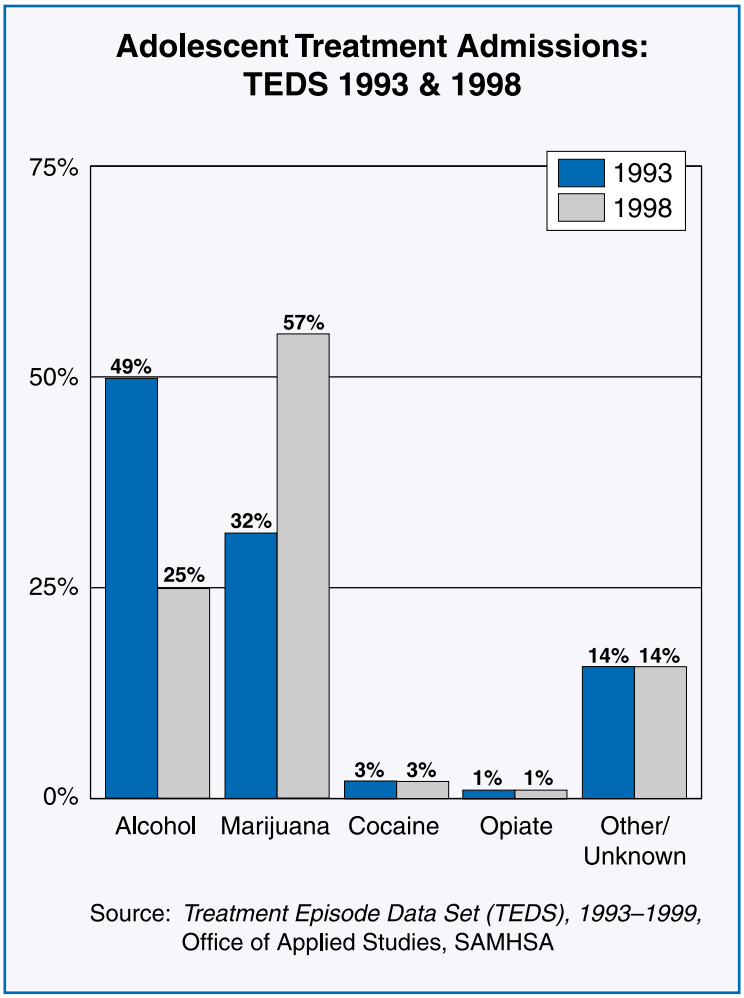
Among adolescents, female admissions exceeded male admissions only for methamphetamine/amphetamine abuse (55 to 45 percent). Admissions of adolescent males and females were nearly equal for heroin abuse. More males than females were admitted for treatment of all other substances.

Adolescent admissions for heroin abuse more than doubled between 1993 and 1998 (752 to 1794). During the same period, adolescent admissions for methamphetamine abuse increased by 185 percent (1,159 to 3,299).

Other Demographic Groups

TEDS data for other demographic groups showed that admissions for smoked cocaine and heroin were generally older than for those drugs usually associated with adolescents (marijuana, hallucinogens, inhalants). Fifty-five percent of admissions for heroin and 66 percent of admissions for smoked cocaine were age 30 to 44.

Admissions for abuse of alcohol alone declined from 34 percent of treatment admissions in 1993 to 26 percent in 1998. Almost half of TEDS admissions in 1998 (47 percent) reported alcohol as the primary substance, but 43 percent of these admissions reported secondary drug abuse as well.



Source: *Treatment Episode Data Set (TEDS), 1993–1999,* Office of Applied Studies, SAMHSA

The proportion of opiate admissions was equal to that for cocaine admissions in 1998. The proportion of admissions for primary opiate abuse increased from 13 percent in 1993 to 15 percent in 1998.

While most admissions for primary heroin abuse have been *injectors* of heroin, the proportion declined from 74 percent in 1993 to 67 percent in 1998, while the proportion of heroin admissions for *inhalation* increased from 23 percent in 1993 to 28 percent in 1998.

The proportion of admissions for primary cocaine abuse declined from 18 percent in 1993 to 15 percent in 1998. Smoked cocaine represented 73 percent of all primary cocaine admissions in 1998, a proportion that remained stable over the time period from 1993 to 1998.

The proportion of admissions for abuse of methamphetamine/amphetamine and other stimulants increased from 2 percent to 5 percent between 1993 and 1998. The increase in admission rates for methamphetamine/amphetamine spread east from the Pacific States into the Midwest.

Methamphetamine/amphetamine admissions were predominantly white (80 percent). The next largest racial/ethnic group was persons of Mexican origin, at 8 percent. Forty-seven percent of the methamphetamine/amphetamine admissions were female.

For a copy of the *Treatment Episode Data Set (TEDS): 1993-1998*, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Web access: Type **www.samhsa.gov**, click on SAMHSA's Clearinghouses, and then click on NCADI.

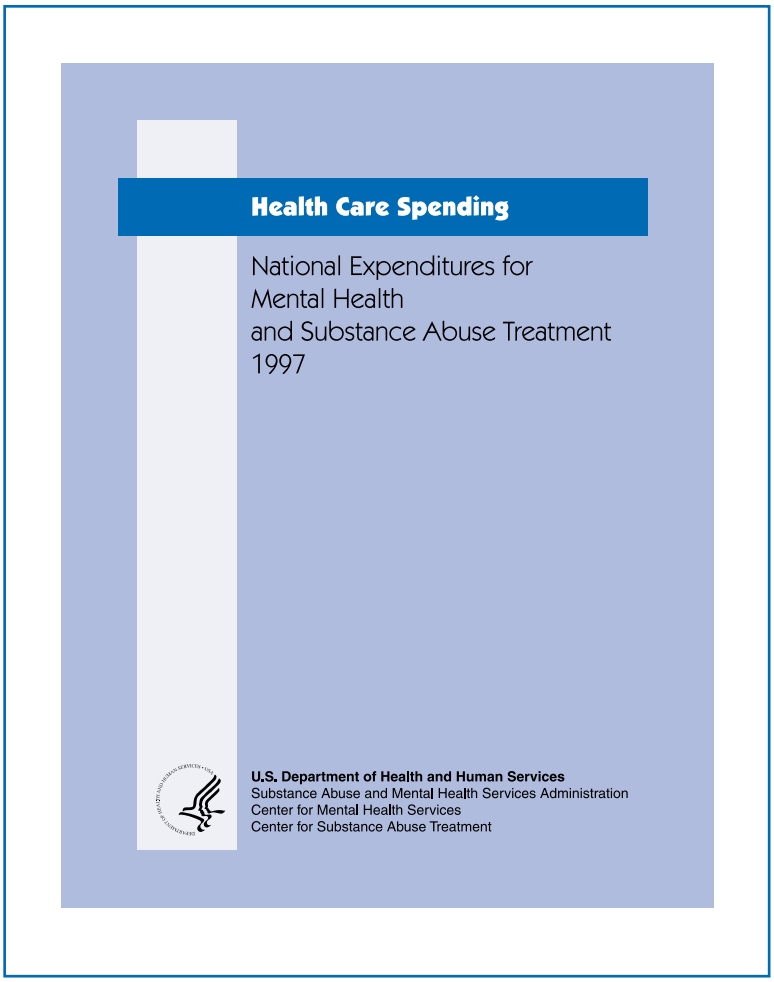
Lower Percentage of National Spending Reported for Behavioral Health Care

An analysis of trends in health care spending reveals that expenditures for mental health and substance abuse treatment (often called "behavioral health care") represented 7.8 percent of the more than $1 trillion in all U.S. health care expenditures in 1997, down from 8.8 percent of the total in 1987. This decline occurred despite the persistent gap between the prevalence of mental and addictive illnesses and treatment utilization documented in *Mental Health: A Report of the Surgeon General* and SAMHSA's National Household Survey on Drug Abuse.

The study, *National Expenditures for Mental Health and Substance Abuse Treatment, 1997,* found that public payers (government agencies) fund the majority of mental health and substance abuse treatment spending—the opposite of all health care funding. While public sources provided 58 percent of mental health and substance abuse treatment services dollars in 1997, they supplied only 46 percent of all health spending. For all health care services, including mental health and substance abuse treatment, public sector spending has increased since 1987. This trend is primarily due to slower growth in private sector spending and rapid growth by Medicare and Medicaid.

Overall, national expenditures for treatment of mental illness and abuse of alcohol and illicit drugs totaled $82.2 billion in 1997. Of this total, 86 percent ($70.8 billion) was for treatment of mental illness, and 14 percent ($11.4 billion) was for treatment of alcohol and drug abuse.

Findings from the study, produced by SAMHSA's Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS), also appeared in a special section of the July/August 2000 issue of the peer-reviewed journal *Health Affairs*.



CSAT Director H. Westley Clark, M.D., J.D., M.P.H., emphasized that, "In the substance abuse area, over 64 percent of treatment dollars came from the public sector. The other 36 percent includes everything spent by private insurers, philanthropy, or out-of-pocket by patients and families. The stigma of substance abuse is preventing adequate health insurance coverage for substance abuse treatment, unlike what is available for treatment of other illnesses."

CMHS Director Bernard S. Arons, M.D., noted, "The study shows a growing trend toward outpatient treatment. Hospital expenditures as a proportion of all mental health and substance abuse treatment spending dropped over 10 percent between 1987 and 1997. Changes in treatment philosophy, coupled with new technologies and, of course, managed care, have all contributed."

He observed that prescription drug spending became a much larger share of mental health spending,

fueled by the increase in sales of antidepressants and new antipsychotic drugs. However, Dr. Arons cautioned, "Medications are only part of the treatment equation; most often, they work best when combined with other forms of psychotherapy—the kinds that the study shows are still not covered on a par with other illnesses."

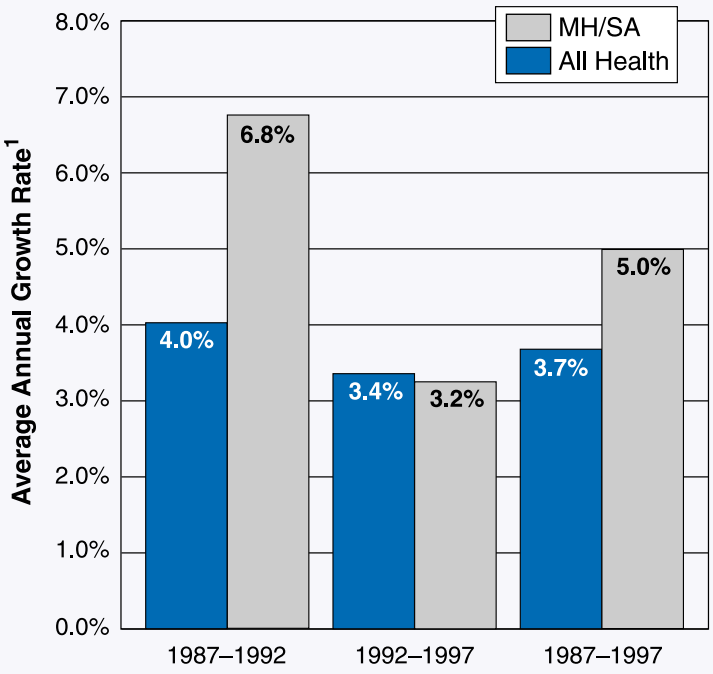
State and local governments play a very substantial role in the funding of mental health and substance abuse treatment. This is most obvious when compared with their role in all health care services. State and local governments supported 28 percent of mental health and substance abuse treatment expenditures in 1997, compared to only 13 percent of all health care services.

The SAMHSA study was designed to provide periodic updates on annual estimates and expenditure trends for mental health and substance abuse treatment in a way that allows direct comparisons with the figures for national health care spending produced by the Health Care Financing Administration. Because the study focuses on expenditures for treatment and not disease burden, estimates include expenditures only for the direct treatment of mental illness and substance abuse. Estimates are categorized by provider type (e.g., community hospitals, physicians, psychiatric hospitals, specialty substance abuse centers) and source of payment (e.g., private insurance, client out-of-pocket, Medicaid, Medicare, and state/local government).

This report is the second in a series of reports planned. Since release of the first report, *National Expenditures for Mental Health, Alcohol and Other Drug Abuse Treatment, 1996*, more refined methodologies have been adopted. The estimates in this report are intended to replace the entire set of prior estimates.

For a copy of *National Expenditures for Mental Health, Alcohol and Drug Abuse Treatment, 1997*, contact SAMHSA's National Clearinghouse on Alcohol and Drug Information (NCADI) at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800)729-6686 (English and Spanish) or 1 (800)487-4889 (TTD). Web access: Type **www.samhsa.gov,** click on SAMHSA's Clearinghouses, and then click on NCADI. Or, contact SAMHSA's National Mental Health Services Knowledge Exchange Network (KEN) at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800)789-CMHS (2647) or (301) 443-9006 (TTD). Web access: Type **www.samhsa.gov,** click on SAMHSA's Clearinghouses, and then click on KEN. Copies of the July/August 2000 issue of *Health Affairs* are also available through these services.

Mental Health (MH)/Substance Abuse (SA) Expenditures Grew More Slowly Than All Health Between 1987 and 1997



Source: National Estimates of Expenditures for Mental Health and Substance Abuse Treatment, 1997.

[1]Inflation-adjusted, National Health Accounts-equivalent expenditures.

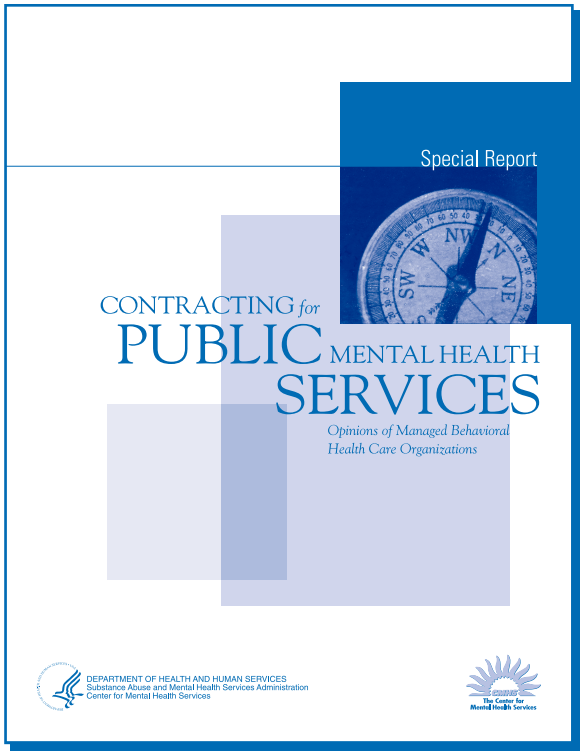
Contracting For Public Mental Health Services

Representatives from managed behavioral health care organizations (MBHOs) suggest ways to improve public sector contracting for managed mental health services in a report released recently by SAMHSA's Center for Mental Services (CMHS).

The report, *Contracting for Public Mental Health Services: Opinions of Managed Behavioral Health Care Organizations*, summarizes the experiences of four MBHOs that hold public sector managed care contracts. Four representatives of these MBHOs participated in a focus group (structured discussion), and two others were interviewed by telephone. Together, the four MBHOs enroll over 106 million members and comprise more than 60 percent of the entire managed behavioral health care market. The views presented in the report are solely those of MBHO representatives.

SAMHSA Administrator Nelba Chavez, Ph.D., said, "Many studies of managed mental health care programs have focused on the opinions and experiences of administrators, providers, and consumers. Historically, the views of MBHOs have not been considered. This groundbreaking report provides important information about how MBHOs view the states' managed care contracting and how they think it could be improved."

CMHS Director Bernard S. Arons, M.D., said, "States are increasingly concerned about their ability to attract qualified bidders for their managed mental health care contracts. This report identifies factors that states should consider to increase the interest of potential bidders and the eventual success of their programs."



Specific recommendations from the study participants include:

- Requests for Proposals should specify the requirements of the payer and ask offerors to describe how they will operationalize these requirements.
- Core benefit packages should be specific and clear in the contract. Expectations for service coordination across health care and social support programs should be reasonable and should support additional service requirements appropriately.
- Clear and specific procurement specifications should be developed before the bidding process.
- Financial design should be compatible with the program design and should permit profit-making. Agreements in which contractors assume financial risk should include a sufficient scope of services and population size to be financially viable and actuarially sound. Reimbursement should accommodate startup and ongoing administrative costs.
- Consumers of mental health services should play an active role in advisory committees focusing on service-delivery issues and member services.
- Performance measures should be tied to program objectives and should reflect those factors the MBHO can reasonably be expected to track.

Excessive financial requirements, inconsistent and poorly specified performance measures, and unresolved program design issues were a few of the problems encountered by MBHOs cited by the participants.

For a copy of this publication, contact SAMHSA's National Mental Health Services Knowledge Exchange Network (KEN) at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-CMHS (2647) or (301) 443-9006 (TTY). Web access: Type **www.samhsa.gov,** click on SAMHSA's Clearinghouses, click on KEN, click on CMHS Programs, and then click on managed care.

Preventive Services To Promote Mental Health, Reduce Substance Abuse

Health insurance plans offering services that can prevent substance abuse and promote mental health could lessen suffering, reduce treatment costs, and improve productivity for millions of Americans, according to a report released by SAMHSA's Center for Mental Services (CMHS) and Center for Substance Abuse Prevention (CSAP).

The report, *Preventive Interventions under Managed Care: Mental Health and Substance Abuse Services*, provides a review of 54 scientific journal articles from 1964 to 1999 documenting the effectiveness of preventive services that promote mental health and reduce substance abuse. The review sought to identify the preventive interventions with the strongest, evidenced-based support in the scientific literature.

"The report reaffirms that programs and services are available that can prevent substance abuse and promote mental health," said SAMHSA Administrator Nelba Chavez, Ph.D. "This report can be used by health care purchasers to demand coverage for preventive interventions and by managed care organizations to strengthen the case for incorporating preventive health care services that are effective and produce cost savings."

The report concludes that six specific services may be of particular benefit from both economic and human perspectives:

- Prenatal and infancy home visits
- Targeted smoking cessation education and counseling, especially for women who are pregnant
- Targeted short-term mental health therapy
- Self-care education for adults
- Presurgical educational intervention with adults
- Brief counseling and advice to reduce alcohol use.

CMHS Director Bernard S. Arons, M.D., noted: "Managed care stakeholders can use this publication as a tool to make better choices in deciding what interventions to offer and provide with the possibility of preventing substance abuse and mental health disorders."

In addition, CMHS recently released the *Annotated Bibliography for Managed Behavioral Healthcare, 1989-1999*. The bibliography includes 410 abstracts covering the published literature on managed behavioral health care over that 10-year period.

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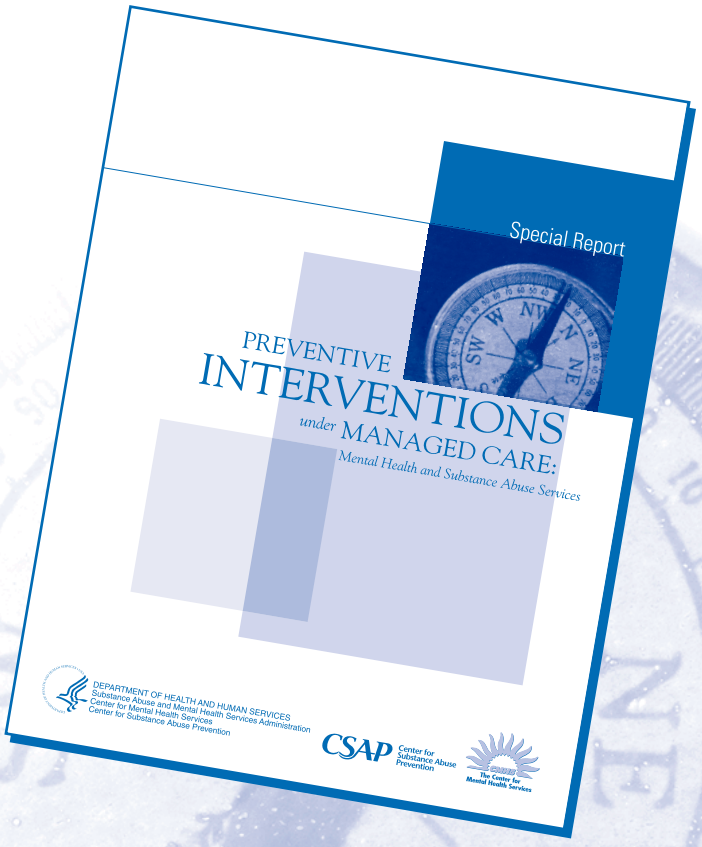

SAMHSA Awards New Grants

SAMHSA's grant awards for Fiscal Year 2000 reflect an ongoing commitment to develop and test new methods for treating and preventing addictive and mental disorders as well as to support and expand existing efforts that continue to show promise.

Among the most significant is a $6.66 million award to support nine grants to study and document effective treatment for women with histories of substance abuse, physical and sexual abuse, and mental illness. The program is supported by all three SAMHSA Centers—the Center for Substance Abuse Treatment (CSAT), the Center for Mental Health Services (CMHS), and the Center for Substance Abuse Prevention (CSAP).

The money is directed at programs that are already grantees for Phase One of the study of **Women with Alcohol, Drug Abuse, and Mental Health Disorders Who Have Histories of Violence**. This new funding will enable grantees to proceed immediately and improve the knowledge base, because they already have established an integrated system of care for women with co-occurring disorders and histories of physical and sexual abuse.

An additional $1 million award will support four study sites and a coordinating center to evaluate children of these women. The goal is to identify models of care that will prevent the intergenerational perpetuation of violence, substance abuse, and mental health problems.

Grants of $740,000 were awarded for the women's programs and grants of $200,000 for the children's study.

"SAMHSA is committed to following through with grants and technical assistance to generate important knowledge on how to develop integrated services for women that work," said SAMHSA Administrator Nelba Chavez, Ph.D. "These grants will help fill in the gaps in what we now know about histories of violence and how they affect treatment of co-occurring disorders. Phase One identified promising models for intervention services," she continued. "Now we must test these models to see what will work to reach women who have suffered complex interactions from trauma, substance abuse, and mental illness."

CSAP and CMHS also jointly awarded $3 million in **Family-Strengthening** grants to 32 research-based parenting and family support service programs focused on reducing substance abuse.

". . . the family plays a key role in how children handle the temptations of . . . illicit drugs."

"Research shows that the family plays a key role in influencing how children handle the temptations of alcohol, tobacco, and illicit drugs," Dr. Chavez emphasized.

The family-strengthening grants are part of the strategy adopted by Health and Human Services Secretary Donna Shalala to support and promote the widespread adoption of research-based family-strengthening approaches. Studies by CSAP have determined that three approaches have the highest evidence of effectiveness in reducing behavioral and emotional problems in youth—parent and family skills training, family in-home support, and family therapy.

Grantees will receive technical assistance and training to select, modify, establish, and test the best prevention practices in their communities from more than a dozen programs shown to be effective.

Biological parents, step-parents, adoptive parents, foster parents, extended family, and other combinations of family members all fall under the definition of family. The target population is not restricted on the basis of age of caretakers or race/ethnicity. Target populations include families in which one or both parents are or have been substance abusers; families with children who exhibit conduct disorders, learning disabilities, or aggressive behavior; families with disabled children; immigrant families, especially in rural areas; adolescent parents; foster care children and their families; and other families that are at high risk.

In another SAMHSA-wide effort, the **Community Action Grant Program,** all three SAMHSA Centers (CMHS, CSAT, and CSAP) awarded 36 grants totaling nearly $5.1 million to local communities to adopt exemplary, proven practices for adults with serious mental illnesses and children with serious emotional disturbances.

CSAT and CMHS are cosponsoring with several Department of Justice (DOJ) agencies a **Cooperative Agreement for a National Center for Mentally Ill and Substance Abusing Youth and Adults Involved with the Justice System**. The $1.1 million award, jointly funded with the National Institute of Corrections, Office of Justice Programs, and the DOJ's Office of Juvenile Justice and Delinquency Prevention, supports efforts to create effective service delivery systems to provide integrated treatment for youth and adults with co-occurring disorders involved with the justice system. The program does not provide direct services to clients.

CSAT has funded a new round of **Targeted Treatment Capacity Expansion** grants for a total of $28.6 million to expand substance abuse treatment capacity in 57 local communities with serious, emerging drug problems or communities with proposed innovative solutions to unmet needs.

"Mayors, town and county officials, and Indian tribal governments have come to us," said Dr. Chavez. "They emphasize the need for Federal leadership in helping communities address emerging drug trends and related public health problems at the earliest possible stages. These grants will help provide rapid and strategic responses to the demand for regional and local services."

"Our experience indicates that an understanding of the client community increases access to treatment, retention in programs, and positive treatment outcomes," said CSAT Director H. Westley Clark, M.D., J.D., M.P.H.

These awards are designed to create clinical and service delivery approaches that are culturally responsive, address the clinical treatment needs of specific populations, propose approaches for outreach to hard-to-reach populations, and use state-of-the-art treatments.

CSAT funded another round of grants for the **Targeted Capacity Expansion Services Program for Substance Abuse and HIV/AIDS Services**. A total $18.5 million will support 43 grants to expand substance abuse treatment and HIV/AIDS services in African American, Hispanic/Latino, and other racial or ethnic minority communities affected by the twin epidemics of substance abuse and HIV/AIDS.

"The goal of this initiative is to demonstrate that outreach to substance abusers, particularly injecting drug users, can reduce their risk for acquiring or transmitting HIV," said Dr. Clark.

Likewise, CSAP awarded additional grants under its **State Incentive Program,** bringing the total to 28 states and the District of Columbia. They are developing and establishing comprehensive strategies to prevent substance abuse among youth. This year, nearly $14 million was awarded to assist governors in seven states to coordinate and leverage all Federal and state resources in this critical effort.

"By collaborating with Federal agencies, state and local governments, and community anti-drug coalitions, we can work toward lowering the serious economic and social costs of illicit substance abuse to our Nation," said Acting CSAP Director Ruth Sanchez-Way, Ph.D.

". . . outreach to substance abusers . . . can reduce their risk for . . . HIV."

CMHS awarded $7.4 million in **Coalitions for Prevention Grants** to 29 states, cities, and counties to develop partnerships to sustain service systems for youth violence prevention and mental health promotion.

Another CMHS program is also geared to youth—the **Cooperative Agreements for Comprehensive Community Action Grants to Promote Youth Violence Prevention, Suicide Prevention, and Resilience Enhancement**. A total of $4.1 million was awarded to 29 communities to establish evidence-based, youth violence and suicide prevention programs. The grantees are required to build collaborations within the community to ensure continuation of the programs.

"These grants provide help for improving the quality of life for people living with mental illness and their families," said CMHS Director Bernard S. Arons, M.D. "One of the ways we can improve mental health services in our country is by always looking for new and innovative ways to make them more accessible."

Other SAMHSA grants include:

Center for Substance Abuse Treatment

The **Minority Community Planning Grants for Integration of HIV/AIDS and Substance Abuse Treatment, Mental Health, Primary Care, and Public Health** awarded $900,000 to six government jurisdictions as part of the Minority AIDS Initiative sponsored by the Congressional Black Caucus.

The effort seeks to provide a mechanism for state and local governments to coordinate a variety of resources and to develop plans that identify community needs in the African American, Latino/Hispanic, and other racial or ethnic communities at high risk of HIV infection.

The **Comprehensive Community Treatment Program** awarded eight grants totaling $2.6 million to evaluate the effectiveness of innovative new methods for substance abuse treatment. These projects address local issues involving special populations in need of substance abuse treatment.

Grantees will study culturally relevant treatments provided in nontraditional settings to special populations such as American Indians, Asian Americans, college students, teens with co-occurring substance abuse and mental disorders, or adult probationers.

A total of $3.9 million, awarded to support 10 grants of approximately $300,000 to $400,000, is earmarked as part of the **Co-Occurring Disorders Study**. These grants are designed to

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identify, refine, test, and document approaches for the delivery of substance abuse services within outpatient substance abuse treatment agencies to persons with co-occurring alcohol or drug and mental health problems. These funds are not available to provide treatment services. The grant program is designed to target populations such as adolescents, homeless people, and adults in methadone maintenance.

The **Community Action Grants for Service Systems Change** awarded $762,299 to stimulate adoption by communities of specific, exemplary service delivery practices shown to have yielded the best results in treating adolescents and adults for alcohol and drug abuse. The grants are designed to bolster service delivery and organization of services.

The **Community-Based Practice/ Research Collaboratives program** awarded $3.1 million in nine grants to improve the quality of substance abuse treatment services by supporting practice-research collaboratives. The program is designed to enable researchers to work with treatment practitioners to focus on problems identified as significant in the community and to enable practitioners to incorporate research findings into their services. Collaboratives are tasked with sharing knowledge among treatment providers, researchers, policymakers, health plan managers, and purchasers of treatment within a community.

Center for Mental Health Services

The **Technical Assistance Center for the Evaluation of Mental Health Systems Change**, a $650,000 continuing grant, provides technical assistance to states and local and nonprofit organizations with a primary focus on adult mental health systems.

Center for Substance Abuse Prevention

A total of $8.1 million was awarded to continue the development and operation of the **Centers for the Application of Prevention Technologies (CAPTs)** in five regional sites. The CAPTs help states and community-based substance abuse prevention programs adopt proven prevention practices based on scientific research.

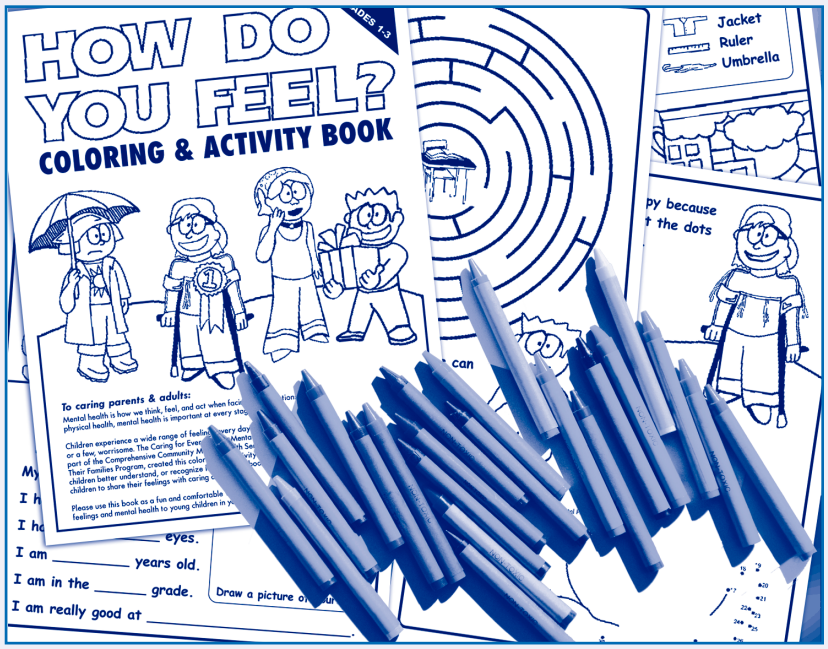
Since fall 1997, CSAP's CAPT grants have enabled states, U.S. territories, Indian tribes and tribal organizations, local communities, substance abuse prevention organizations, and practitioners to adopt and adapt scientifically sound substance abuse prevention strategies and programs to meet the needs of their constituents. The CAPTs use innovative technology including videoconferencing, Webcasting, and online interactive programming to keep programs and states abreast of the latest information.

Resource Helps Children Discuss Feelings

The *Caring for Every Child's Mental Health Campaign*, part of the Comprehensive Community Mental Health Services and Their Families program sponsored by SAMHSA's Center for Mental Health Services, has released an online coloring and activity book for children in grades 1 through 3. The purpose of the online resource is to help young children better understand and recognize their feelings as part of their emotional well-being and to encourage them to share their feelings with caring adults.

SAMHSA News readers are encouraged to post the coloring book or a link to it on their Web sites.

The book is available free of charge at **www.samhsa.gov**, click on SAMHSA's Clearinghouses, click on KEN, click on CMHS programs, and then click on the Children's Campaign.



We Would Like To Hear From You!

SAMHSA News strives to keep you informed about the latest advances in treatment and prevention practices, the most recent national statistics on mental health and addictive disorders, relevant Federal policies, and available resources.

Are we succeeding? We'd like to know what you think.

I found these articles particularly interesting or useful:

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- ❑ **Promising Practices for Children**
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- ❑ **Cocaine Treatment Suggests Model for Methamphetamine**
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- ❑ **Data Show Increase in Marijuana Treatment Admissions for Youth**
- ❑ **Lower Percentage of National Spending Reported for Behavioral Health Care**
- ❑ **Contracting for Public Mental Health Services**
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